Incorporation of spiritual care as a component of healthcare and medical education: viewpoints of healthcare providers and trainees in Nigeria

Incorporation of Spiritual Care as a Component of Healthcare and Medical Education: Viewpoints of Healthcare Providers and Trainees in Nigeria

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Abstract

Background: *Patients frequently want clinicians to be aware of their spiritual values and needs. There is increasing recognition in Europe and North America of the benefits from incorporating spiritual care into overall patient management.*

Methods: *This study captures views of healthcare providers at two maternity units in Lagos on the place for spiritual care within healthcare training and delivery in Nigeria. A questionnaire was designed using a 5-point ordinal scale, with additional free text comments, to capture views of Nigerian doctors and nurses and trainees.*

Results: *Of 86 respondents, 89% agreed that spiritual health contributes to physical health, and83% that an individual's faith can affect health and recovery in the event of illness. 92% acknowledged that religious faith or personal spirituality is significant for many patients and 73% that spiritual care is an important aspect of patient management. Although 71% recognised that patients wanted doctors to be aware of their spiritual needs, only 29% felt that clinicians should share their own spiritual values with patients and respondents were divided on the extent to which as clinicians they should become personally involved with 32% preferring to leave provision of spiritual care to others with specific expertise.58% were supportive of inclusion of training in spiritual care into medical and nursing curricula as an optional component but respondents did not express strong preferences in regard to content or format.*

Conclusion: *In view of the potential benefits, basic training in taking spiritual histories and identifying spiritual needs amenable to specialist intervention is advocated to enable healthcare providers to meet patient expectations in provision of spiritual care.*

Key words: *medical education; nursing education; Nigeria; whole-person care*

INTRODUCTION

Globally, a spiritual dimension is increasingly being recognized as an important aspect of overall health status.[1-3] Spirituality can be defined in terms of 'personally held beliefs, values, and practices' and 'awareness of the ultimate meaning and purpose of life'.Spirituality may be associated with, but should be differentiated from, religion or religiosity, which imply 'an expression of spiritual belief through an organized system of rituals and practices'.[4,5] In quality of life questionnaires, patients consistently score spiritual matters as high on their list of concerns.[6-11]'Whole person medicine' is regarded as a collective term to describe all aspects of care required to restore and improve health in an individual. Such aspects include physical, psychological, social and cultural care but also spiritual care.[12,13]While psychological and social aspects of illness are often addressed during routine clinical assessment, the spiritual dimension is still frequently overlooked and opportunities are missed to mobilise appropriate spiritual resources as a component of the overall therapeutic strategy in provision of care for the individual patient in their given situation. There is growing international recognition of the importance of whole-person medicine[14-17]and the need for basic training of healthcare personnel to provide effective spiritual care when appropriate[18-21]

There are widespread differences in culture, religious practice and healthcare systems worldwide. The impact of medical specialty and working environment on the healthcare professional's own spirituality is equally unclear.[22]How the individual clinician's own personal spirituality and local cultural and religious influences on the clinical environment collectively shape both local clinical practice and the teaching of whole person medicine to healthcare trainees at an institutional level is uncertain[23,24]; the published literature has been dominated by research from North America.[25-32]Few studies have addressed views or practices specifically relating to provision of spiritual care as a component of healthcare delivery in the majority world[33,34], specifically Nigeria. One notable recent study is that conducted in Obstetrics Units in tertiary teaching hospitals in South-West Nigeria by Adanikin and co-workers[35]who reported that the majority of Nigerian women attribute importance to spiritual help during pregnancy and childbirth and half of them actively seek help via prayer/mission houses. A significant majority of those respondents felt that healthcare professionals should give fuller consideration to their patients' spiritual needs in order to encourage uptake of hospital maternity services. There was also a prevalent view that clergy should be allowed to be present in maternity hospitals to pray with patients during labour. The authors concluded that clinicians should receive basic training in taking spiritual histories to be able to recognise when to make appropriate referral to experienced clergy for specialist spiritual care. However, the views of healthcare providers were not ascertained for comparison. We recently devised a questionnaire to record the attitudes and behaviours of healthcare staff and students in relation to the spiritual dimension to health and provision of spiritual care and used this to report both on the opinions of Faculty and students at a medical school in the United Kingdom[36]and also respondents from at a rural community hospital in Uganda.[36,37]

The purpose of the current study was to explore the attitudes of healthcare personnel working in hospitals in urban Lagos, Nigeria, about addressing spiritual issues with patients as a component of healthcare delivery and their views about incorporating training in provision of spiritual care into undergraduate medical and nursing curricula. Inter-professional differences were explored by comparing the viewpoints of doctors and medical students with those of nurses and student nurses. The influences of respondent age, professional experience, gender, and tribal affiliation were also considered. Furthermore, opportunity was taken to compare the latest findings with those previously reported for the United Kingdom and Ugandan cohorts.[36,37]

METHODOLOGY

Study design

A previously devised self-administered questionnaire was employed.[36] The questionnaire was designed after thorough review of the published literature and discussion with relevant stakeholders, including hospital chaplaincy staff at the author's institution. Following piloting of the questionnaire with a small group of students and Faculty, and advice from a medical statistician on standardization of question format to enable quantitative analysis, the questionnaire was further refined and ethical approval for use was granted by the authors' Medical School's Research Ethics Committee. A small number of questions only relevant to local QUB Medical School / United Kingdom practice were removed but otherwise the questions were reproduced as a whole in the current study. The questionnaire in its current form has also been employed in a similar study undertaken in a rural community hospital in Uganda.[37] The first part of the questionnaire gathered demographic information. Subsequent study questions were grouped into three domains, structured as follows:

Domain 1: attitudes to whole person medicine

Respondents graded their attitudes to the various components of whole person care (physical, psychological, social, spiritual) on a scale ranging from irrelevant to very important.

Domain 2: attitudes to spirituality and illness

This domain explored issues related to the interplay between spirituality and health, including the contribution of spiritual beliefs to health status. Respondents were asked to explore the relationship between patient and physician spirituality and whether medical staff should share personal views on spirituality with patients.

Domain 3: attitudes to the training of healthcare staff in spiritual care

This domain focused on medical education and explored views on the training and assessment of medical and nursing students in spiritual aspects of healthcare.

The questionnaire ended with a free text box to allow any views expressed to be expanded or clarified, and to facilitate any other comments on the subject. Ethical approval for use outside of the authors' own institution was granted by Queen's University Belfast Medical School's Research Ethics Committee. In Nigeria, ethical approval was obtained from the Medical Directorates of Lagos Island Maternity

Hospital and St Nicholas's Hospital. The printed questionnaire was provided by one of the authors (AA who at the time of the study was a final year Medical Student undertaking an eight-week clinical elective at the two hospitals). An opportunity sampling strategy was adopted. Following an informal seminar in each institution to introduce the purpose of the research study, all healthcare staff and trainees based at Lagos Island Maternity Hospital and the Obstetrics and Gynaecology Department of St Nicholas's Hospital were invited to participate. At the time of the study there were approximately 30 medical staff and 40 nursing staff at Lagos Island Maternity Hospital, and 15 medical staff and 10 nursing staff at the Obstetrics and Gynaecology Department at St. Nicholas's Hospital. In addition to qualified staff, this included trainee nurses on attachment at Lagos Island Maternity Hospital and medical students on clinical attachment/elective in obstetrics and gynaecology at St Nicholas's Hospital. Blank questionnaire forms were left at the reception areas of each of the hospitals for completion. Participation was voluntary. Completed questionnaires were returned anonymously via a box placed in a central collection point in the reception areas of each of the hospitals.

Data Analyses

Simple descriptive statistics were used to describe the distribution of responses for each question. To facilitate quantitative data analysis, a five-point Likert scale was chosen to record responses for most of questions (except for two closed questions requiring a simple YES/NO answer and one question where participants were asked to select options from a list provided). Capture of demographic data was undertaken to facilitate sub-group analysis. Differences in responses regarding value attributed to each of the various dimensions of care were analysed by one-way analysis of variance (ANOVA) with post-hoc comparison by Dunnett's multiple comparison test. Differences in responses to individual questions between sub-groups of respondents or between the entire cohort of participants in the current study and previously published cohorts[36,37] were analysed by Student's t-test. $P<0.05$ was regarded as significant. Although the intention had been to analyse any free text comments recorded at the end of the questionnaire by thematic analysis, this was not required due to the small number of free text comments received.

RESULTS

Demographics of respondents

Characteristics of the respondents are presented in Table 1.Responses were obtained from86 personnel based at either Lagos Island Maternity Hospital or the Obstetrics and Gynaecology Department of St Nicholas's Hospital. The former is a large state-run hospital while the latter is a smaller private hospital providing primary, secondary and tertiary care. Response rates in each hospital facility were estimated to be >90%. 73% of the respondents were of Yoruba tribal affiliation, 98% professed belief in God/a Higher Power, and 91% had not previously received any formal training in provision of spiritual care to patients. For the 9% who indicated that they had received some training, this comprised training provided by their local churches rather than formal training in a healthcare setting. The majority (70%) of respondents were female,

but there was equal representation of both medical (49%) and nursing (51%) staff and students.

Table 1. Characteristics of the respondents (n=86)

Characteristic	Response Percent	Response Count
Occupation		
Medical doctor	44.2	38
Nurse	34.9	30
Medical student	4.7	4
Nursing student	15.1	13
Midwifery student	1.2	1
Age		
<20 years	11.6	10
20-30 years	46.5	40
31-40 years	23.3	20
41-50 years	12.8	11
> 50 years	5.8	5
Gender		
Male	30.2	26
Female	69.8	60
Country of birth		
Nigeria	100	86
Ethnicity		
Yoruba	73.3	63
Igbo	18.6	16
Ebira	2.3	2
Other	5.8	5
Institution		
LIMH	74.4	64
St Nicholas's Hospital	25.6	22
Received Training Previously	9.3	8
Belief in God/Higher Power	97.7	84

Domain 1. Attitudes to whole person medicine

Attitudes of the entire Nigerian cohort to the various components of whole person care are summarised in the first section of Table 2**.** There was overwhelming agreement (composing very important and important responses) that physical (99%) and psychological issues (97%) are important. Although less strongly rated (fewer very important responses), most respondents also agreed that social (99%) and spiritual issues (73%) were important, spiritual issues significantly less so ($p<0.001$) when compared against each of the other aspects of patient management (mean±SE: 2.01±0.12 spiritual care v 1.26±0.06 physical care, 1.37±0.05 social care, 1.30±0.06 psychological care, where 1= very important, 5= irrelevant). Sub-group analysis indicated that between the professions, doctors attributed more importance to social care than nurses did (1.24±0.08 v1.50±0.07, mean ± SE, $p<0.05$). Female respondents (1.85±0.12 v 2.39±0.28, mean ±SE, $p<0.05$) were more likely to recognise the importance of spiritual care than their male counterparts, as did respondents from St Nicholas's Hospital relative to those from LIMH (1.50±0.15 v 2.19±0.16, mean ± SE, $p<0.05$). No other significant differences were noted between subgroups. Overall, more (>50%) respondents selected counselling and intercessory prayer as being important in the provision of spiritual care for patients from the choices listed (Table 3).

Table 2. Tabulated responses for the entire group of respondents, presented as actual number n (with response frequency given in brackets as percentage of the total respondent number, n= 86).

Attitudes to whole person medicine	Very important	Important	Neutral	Little importance	Irrelevant
Physical treatment (drugs, surgery)	67 (78)	18 (21)			**1 (1)**
Social care	55 (64)	30 (35)	1 (1)		
Psychological care	63 (73)	21 (24)	1 (1)	**1 (1)**	
Spiritual care	36 (42)	27 (31)	14 (16)	**4 (5)**	**5 (6)**
Attitudes to influence of spirituality in illness	**Strongly Agree**	**Agree**	**Neutral**	**Disagree**	**Strongly disagree**
Spiritual health contributes to physical health	34 (40)	42 (49)	5 (6)	2 (2)	3 (3)
Religious faith or personal spirituality is an important aspect of lives of many patients	38 (44)	41 (48)	4 (5)	3 (3)	
Patients generally want doctors to be aware of their religious / spiritual values and needs	21 (24)	40 (47)	21 (24)	4 (5)	
Doctors should leave spiritual care to chaplains or others	8 (9)	20 (23)	28 (33)	19 (22)	11 (13)
An individual's faith and spiritual belief can affect their response to their clinical diagnosis and prognosis	35 (41)	36 (42)	9 (10)	5 (6)	1 (1)
Sometimes patients recover for reasons which cannot be explained medically or scientifically	36 (42)	36 (42)	7 (8)	5 (6)	2 (2)
	Never	**Occasionally**	**Certain circumstances**	**Only if invited to**	**Always**
Health care workers should share their own spiritual beliefs with patients	9 (10)	16 (19)	38 (44)	20 (23)	3 (3)
Attitudes to spiritual care in training of healthcare staff	**Strongly Agree**	**Agree**	**Neutral**	**Disagree**	**Strongly disagree**
Instruction regarding world religions and faith practices should be part of medical/nursing undergraduate curriculum	4 (5)	43 (50)	18 (21)	15 (17)	6 (7)
Instruction in spiritual care is best delivered as an optional component for those who have a particular interest	7 (8)	43 (50)	15 (17)	17 (20)	4 (5)
Instruction in spiritual care should be incorporated into the core curriculum for all students	7 (8)	29 (34)	23 (27)	19 (22)	8 (9)
Instruction in spiritual care should be delivered by doctors and nurses	5 (6)	24 (28)	34 (40)	16 (19)	7 (8)
Training of healthcare workers should include shadowing hospital chaplains or others expert in spiritual care	6 (7)	30 (35)	27 (31)	15 (17)	8 (9)

Table 3. Respondents were asked to select a maximum of three aspects from those listed which they considered were most important in provision of spiritual care. The responses are presented as n (percentage of cohort selecting this aspect). Some respondents selected less than three options.

Number of respondents	**86 (100)**
Aspect of spiritual care	
Counselling	58 (67)
Sacred music and songs	16 (19)
Religious rites and ceremonies	15 (17)
Healing services	15 (17)
Access to a chaplain	18 (21)
Sacred texts/readings	10 (12)
Intercessory prayer	46 (53)
Contact with member of patient's own faith community	14 (16)

Domain 2. Attitudes to spirituality in illness

Most respondents acknowledged that spiritual health contributes to physical health (89% strongly agreed or agreed) and that patients can sometimes recover for reasons that cannot be explained medically or scientifically (84% strongly agreed or agreed) (Table 2). They considered religious faith/personal spirituality to be an important aspect of the lives of many patients (92% strongly agreed or agreed), affecting response to their clinical diagnosis and prognosis (83% strongly agreed or agreed). The majority also agreed that patients generally wanted doctors to be aware of such religious values and spiritual needs (71% strongly agreed or agreed). Qualified healthcare professionals were more likely to agree with this statement than trainees (mean +SE 1.97+0.10 v 2.53+0.17, $p<0.05$, where 1= strongly agreed, 5= strongly disagree). Despite this, respondents were evenly divided on whether to leave provision of spiritual care to chaplains or others with relevant expertise (34% agree v 35% disagree) and 67% responded that healthcare workers should only share their own personal spiritual beliefs with patients under certain circumstances (44%) or when specifically invited (23%) to do so.

Domain 3: Attitudes to inclusion of spiritual care training for health care staff

55% respondents agreed that teaching to provide awareness of world religions and faith practices should be incorporated into the undergraduate medical/nursing curriculum while only 24% disagreed. Opinion was divided as to whether delivery of spiritual care should also be addressed and whether this should be delivered as a compulsory or optional component: 42% agreed v 31% disagreed that this should be

compulsory while 58% agreed v 25% disagreed that this should be optional (Table 2). Consensus was lacking regarding whether such teaching should be delivered by doctors and nurses (34% agreed v 27% disagreed) or left to others and whether trainees should have opportunities to shadow hospital chaplains or others expert in provision of spiritual care (42% agree v 26% disagree). Younger respondents (≤30 years) were more likely to agree (2.42±0.12 v 3.14±0.19, $p<0.05$) that instruction regarding world religions and faith practices should be part of the undergraduate curriculum and that instruction in spiritual issues was best delivered as an optional component for those with a particular interest (2.42±0.13 v 2.92±0.18, $p<0.05$).

Analyses of free text comments

Only 8 of 86 respondents (9%) added free text comments. The importance of spiritual care was recognised:

'*spirituality of the patient should be taken seriously as the spiritual dimension affects the physical life'* ***[female nursing student]***

'I welcome the questionnaire and opportunity to address spiritual care as this would be beneficial for patients and healthcare workers' ***[male nursing student]***

One, from an evangelical Christian background, welcomed opportunities to share faith but recognised the need to respect professional boundaries:

'as healthcare workers, we can use opportunities to lead others to God but need to be careful because of diverse spiritual views' ***[female doctor]***

But another expressed concern about manipulation and potential to cause harm:

9required or desired result' ***[female nurse]***

One struck a note of caution taking the view that healthcare workers should not be the ones to provide spiritual care as they might not have appropriate expertise:

'best to leave doctors out of spiritual aspects of healthcare as this requires a high level of personal spiritual maturity and wisdom which is often confused here with spiritual fervour' ***[male doctor]***

Others stressed that spirituality is a personal matter and delivery of training in the curriculum should not be compulsory:

'if incorporated into the curriculum do not impose, let student choose for themselves' ***[female nurse]***

DISCUSSION

Globally, evidence is accumulating that patients generally do want doctors to be aware of their religious and spiritual values and needs.[6-11] This observation can be further illustrated by the study conducted by Adanakin and co-workers amongst patients in South-West Nigeria.[35] Furthermore, there is growing recognition, including amongst healthcare workers, that religious faith or personal spirituality is an important aspect of the lives of many patients and that spiritual health can impact physical health. The benefits that can be derived from incorporating spiritual care as an integral component into overall patient management are increasingly recognised.[14-17] Despite this, there is evidence of an apparent mismatch between clinicians' willingness to engage in

provision of spiritual care and the expectations of many patients in this regard. Data on the generalizability of views of healthcare workers across cultures and organisations are largely lacking.[22-24]Recognition of contrasting views across institutions and cultures could usefully inform recommendations regarding provision of spiritual care tailored at local level and ultimately benefit patients. Therefore, it was of interest to survey the views of Nigerian healthcare workers and trainees. The findings could then be usefully compared with the views of patients from their own country, as reported previously by Adanakin's group[35]and also with those of healthcare workers and trainees from other countries, as reported by others including ourselves.[25,36,37]Most Nigerian healthcare workers and trainees did agree that spiritual health contributes to physical health, an individual's faith can affect their response to their diagnosis and prognosis and patients sometimes recover for reasons that cannot be explained medically or scientifically. They also acknowledged that religious faith or personal spirituality is significant for many patients and that spiritual care is an important aspect of patient management. Regarding provision of spiritual care, they prioritised counselling and contact with others, including through sharing of prayer, above more formal practices such as sacred music, readings and religious rites, suggesting a greater emphasis on personal spirituality and connectedness than on observation of religious practice. Although the majority recognised that patients wanted doctors to be aware of their spiritual needs and values, there was still a perceived reluctance by many to share their own spiritual values with patients and respondents were divided on the extent to which as clinicians they should become personally involved rather than leave provision of spiritual care to others.

In comparison to responses from Faculty and students at Queen's University Belfast Medical School, United Kingdom[36](a group predominantly reflecting medical trainee viewpoints and excluding nurses or nursing students), Nigerian healthcare staff and students shared a similar view that although important (73% strongly agreeing or agreeing in the current study v 61% in the UK study), spiritual care was not as important as other aspects of care in the management of patients; yet both groups agreed that spiritual belief can affect patients' responses to their diagnosis and prognosis. (83% strongly agreeing or agreeing in the current study v 75% in the UK study). Nigerians were more likely than those from UK to agree that patients wanted healthcare personnel to be aware of their spiritual values and needs (71% v 45%)and less opposed to healthcare workers sharing their own spiritual beliefs with patients (80 % of UK respondents felt that healthcare workers should never or only occasionally share their own spiritual beliefs with patients v 29% of Nigerian respondents). Both cohorts agreed that healthcare workers who choose to share their own spiritual beliefs with patients should only do so under special circumstances when specifically invited to do so by their patients. The level of atheism in Nigeria currently is estimated to be <2% of the population[38], contrasting with ~25% in United Kingdom overall (Northern Ireland, ~10%).[39–41]However, fewer Faculty, and to an extent fewer medical students, in Belfast expressed belief compared to the general

population. Similar trends have been identified in studies examining the views of medical students and Faculty relative to those of patients in USA.[42]60% of UK population are Christian (82% in Northern Ireland).[39]-[41] In Nigeria, the Igbo tribe is predominantly Christian while the Yoruba tribe is equally divided between Christians and Muslims; overall the majority of respondents to the questionnaires in both countries were from a Christian background.[38] Recent high profile reports in the national press and increasing secularisation may have prompted greater caution in the willingness of UK respondents to share their own spiritual beliefs with their patients[43,44] and prompted the publication of the General Medical Council guidance on maintaining appropriate professional boundaries in regard to spiritual care.[45]Formal recognition of organised hospital chaplaincy services within the structure of UK National Health Service may also reduce willingness of clinicians to become more directly involved in provision of spiritual care themselves.

When compared to the survey of native Ugandans reported previously[37](omitting non-Ugandan respondents from the cohort from the community hospital in rural Uganda), Nigerian healthcare workers and students attached less importance to spiritual care as an aspect of patient management than their East African counterparts (Nigerian 2.01±0.12 v Ugandan 1.46±0.08, mean±SE, $p<0.001$, where 1= strongly agree, 5= strongly disagree). Similarly, they were less strongly inclined to the view that spiritual health influences physical health (Nigerian 1.81±0.10 v Ugandan 1.53±0.09, $p<0.05$) despite similarly high levels of self-reported belief in God/Higher Power (>95%) in both cohorts. Furthermore, in relation to training, Ugandan respondents were more in favour of incorporating instruction in world religions and faith practices and provision of spiritual care into core undergraduate medical and nursing curricula (Ugandan 2.20±0.11 v Nigerian 2.72±0.11, $p<0.01$)and more open to avail of opportunities to shadow chaplains or others with expertise in provision of spiritual care (Ugandan 1.93±0.11 v Nigerian 2.88±0.11, $p<0.001$). Nigerians tended to be neither strongly in favour nor strongly opposed. However, Kagando Hospital operates under the auspices of a Christian Missionary Organisation, and that combined with the influence of the rural setting of Kagando in south-western Uganda rather than the urban setting in Lagos could possibly affect intensity of belief and adherence to faith practices and account for the differences observed in responses between the two settings.

Paradoxically, Nigerians were more strongly of the opinion that patients wanted clinicians to be aware of their spiritual concerns and needs (Nigerian 2.09±0.09 v Ugandan 2.44±0.13, $p<0.05$). Despite this, Nigerian respondents were less inclined to disagree that provision of spiritual care should be left to chaplains and/or other faith representatives (Nigerian 3.06±0.12 v Ugandan 3.71±0.12, $p<0.001$, where 1= strongly agree, 5= strongly disagree)which is in line with their reduced willingness to attribute value to spiritual care. Medical students who have shadowed a hospital chaplain in Belfast invariably find this an insightful and invaluable experience even when they themselves do not profess

strongly held, or indeed any, religious belief.[20] Having shadowed a chaplain on ward rounds, they develop a greater awareness of the benefits of spiritual care for all patients, even for those patients who do not have strong religious faith or indeed, any. They recognise that much of the interaction between chaplain and patient is not overtly religious in content.

Current opinion regarding provision of spiritual care within the healthcare setting has drawn largely on studies originating in North America[25-32] and might not reflect socio-cultural and religious diversity globally. The current study will assist comparisons between the developed and majority world and will be of specific interest to those involved in delivery of healthcare and training of medical and nursing students in Nigeria, particularly in the context of provision of obstetric care. Assessment of locally prevailing views may be the best way to plan such training and incorporation of spiritual care into clinical practice. Healthcare workers in Nigeria do seem to acknowledge the influence of spirituality on health and the importance of spiritual care; indeed more experienced clinicians were more inclined to acknowledge that patients wanted them to be aware of their spiritual needs. No significant differences in attitudes to provision of spiritual care were detected between the representatives of the two professions surveyed. Given the expectations of patients and the perceived benefits of spiritual care, reluctance of healthcare workers to become personally involved in provision of such care, possibly due to lack of experience or confidence in their own ability, should be addressed. None of the respondents had received any formal training in this regard although several cited informal workshops and seminars facilitated by their own faith communities. It is encouraging that younger respondents were more open to provision of formal training, albeiton an optional basis. Consideration should be given to providing basic training for both medical and nursing students in taking spiritual histories from patients[13] to identify spiritual needs that might benefit from referral to others with more specialist expertise in provision of spiritual care, such as chaplains. Opportunities for healthcare trainees to directly observe the interactions between chaplains and other faith representatives with patients in the hospital setting[20,35] could also prove useful.

Authors' contributions

DB and MH proposed and supervised this research studentship and assisted with study design and data analysis and interpretation. AA was at the time of this study a 5th Year medical student at Queen's University Belfast Medical School undertaking her final year overseas clinical elective; she coordinated distribution of the questionnaire and collection of the data in Lagos, Nigeria.

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